VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 3, 2014

Mr. Eric Fritz, Administrator
Woodstock Terrace
456 Woodstock Road
Woodstock, VT 05091-9759

Dear Mr. Fritz:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 20, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1005	A. BUILDING: _____ B. WING _____	C 08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTOCK TERRACE	456 WOODSTOCK ROAD WOODSTOCK, VT 05091

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R100	Initial Comments: An unannounced onsite re-licensing survey and complaint investigation of two self-reports was conducted by the Division of Licensing and Protection from 08/18/14 through 08/20/14. The findings are as follows:	R100	**R146** A monitoring device was placed in resident # 5's unit on August 18, 2014 and is still in place. Residents on the memory impaired area have been assessed for the ability to communicate their need for assistance. Any resident assessed unable to communicate the need for assistance will have a monitoring device placed in their unit and/or have a care plan for regular safety checks by the resident assistant when in their unit and their service plans have been updated. The Health Services Director will assess any new resident moving onto the memory impaired area for ability to communicate the need for assistance and create an appropriate plan of care to meet their needs and screen existing residents on an ongoing basis for a decline in their ability to communicate the need for assistance and update the care plan accordingly.	
R146 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review the nurse failed to provide instruction and supervision to all direct care personnel regarding each resident's health care needs to delegate nursing tasks as appropriate regarding resident safety and a resident's current treatment regimen. The findings include the following: 1. Per medical record review, Resident #5 admitted on 4/6/11 with diagnoses to include Alzheimer's Disease, Coronary Artery Disease, Glaucoma and Behavioral Symptoms of severe distress. Per observation during a facility tour on 8/18/14 at 10:21 AM, the resident is observed to be in bed with bilateral 1/2 side rails in the up position, lying on an alternating pressure mattress and has a protective mat on the right side of her bed on the floor to prevent injury in case of a fall. Resident assessment and service plan dated 8/1/14 signed by the Registered Nurse (RN),	R146		

R146, R172, R176, R179, R181, R188, R206, R208, R224, R247 + A962 POC's accepted 10/1/14
MBertrand RN/PMC

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R146	Continued From page 1 identifies that resident requires total care by staff, is transferred by two (2) persons physically assisted, is totally dependent on staff for all meals and nourishments, is unable to control bowel and bladder requiring staff assistance for toileting/incontinent care, is receiving Hospice Care and Resident #5 requires behavior monitoring/management. Resident service plan identifies that Resident #5 has difficulty speaking and staff is to assist with communication due to overall decline and end of life. Per observation during tour at 10:21 AM, Resident #5 is unable to ambulate independently to call light (pull-cord), located in the bathroom, in the apartment off the bedroom. When the Concierge (who was conducting the tour) was asked, how does the resident notify staff if s/he needs assistance? The response was that s/he has a monitor for sound in the room. The monitor could not be located and after inquiring, confirmation was made at approximately 10:30 AM, by the Health Director, that a monitoring unit was on order and that the resident is unable to utilize the pull-cord to alert staff if s/he is in need. Health Director also confirms that the Service Plan for Resident Attendants (RA) does not identify a monitor for sound to be kept in the resident's room to identify if resident is in distress or in need of assistance. 2. Per medical record review on 8/20/14 at 11 AM, the Service Plan for Resident #5 dated at the time of an update 8/2/14, identifies in hand writing, Desitin cream applied to buttocks and coccyx area for protection from wetness/incontinence to promote comfort and healing of coccyx area. Resident Care Attendants (RA's) are the designated staff to	R146	The Health Services Director will report to the Quality Assurance Committee on a quarterly basis to the status of any residents unable to communicate their need for assistance. Resident # 5's service plan and the RA care plan have been updated and now match. The Health Services Director or his designee has reviewed all other service plans and RA care plans to assure that both plans match. The Health Services Director or his designee will conduct random audits of the service plans and RA care plans to assure that they match and report the findings of those audits to the QA committee on a quarterly basis.	10/24/14 10/24/14

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R146	Continued From page 2 apply the Desitin Cream during incontinent care. The service care plan is stored in the medical record in the main Nurses station located on the 2nd floor. RA service plan is stored on the 1st floor (Memory Care Unit), where the resident resides. The RA service plan does not contain the treatment necessary to prevent skin breakdown and comfort. The two (2) service plans do not match the necessary care for Resident #5's current status. Per interview on 8/20/14 at 11:26 AM confirmation is made by the Health Director that the two service plans do not match.	R146		
R172 SS=B	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that prescription and over the counter medications are properly labeled as required by facility policy. The findings include the following: 1. Per observation on 8/18/14 at 11:47 AM, of the Medication Cart in the Assisted Living Residence, for Resident #7, a prescription of Simethecone 80 milligram (mg.) tablets was noted with no expiration date on the prescription	R172	**R172** All medications currently being administered are labeled with compliant expiration dates. All medications entering the facility will be checked for expiration dates. Any medication without an expiration date will be rejected. The Health Services Director will conduct random audits to assure compliance and correct any non-compliance. The results of these audits will be reported to the Quality Assurance committee on a quarterly basis.	10/24/14

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R172	Continued From page 3 label. This was confirmed by the Licensed Practical Nurse at 11:47 AM. 2. Per observation on 8/18/14 at 11:49 AM, of the Medication Cart in the Assisted Living Residence, for Resident #8, a prescription of Lasix 20 mg. tablets, has no expiration date on the prescription label. This was confirmed by the Licensed Practical Nurse at 11:49 AM. 3. Per observation on 8/18/14 at 12:50 PM, of the Medication Cart in the Assisted Living Residence, bottles of the following medications were stored with hand written dates on the prescription labels, but there is no identification as to what the hand written dates define: a) Amlodipine Besylate 10 milligram (mg.) tablets has a dated 7/15, b) Omeprazole 20 mg. capsules dated 7/15, c) Isosorbide 30 mg tablets dated 8/15, d) 7 bottles of various over the counter medications with dates of 7/15, 8/15 and 11/14. Confirmation by the Licensed Practical Nurse at 12:58 PM confirms that there are no expiration dates identified on the prescription labels of the above listed medications. 4. Per observation on 8/18/14 at 2:07 PM, of Medication Cart in the Memory Care Unit, for Resident #5, an unopened bottle of liquid Tylenol has no expiration date on the prescription label. This was confirmed by the Resident Attendant on 8/18/14 at 2:08 PM. Facility Policy labeled Medication Management dated revised 1/14/13 identifies labeling requirements to include expiration dates.	R172		

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R176	Continued From page 4	R176		
R176 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that outdated medications are promptly disposed of in accordance with the home's policy and applicable standards of practice. For 1 of 6 sampled residents, the following outdated medications were located in the locked medication cart in the Assisted Living Residence. The findings include the following: Per observation on 8/18/14 at 12:38 PM, for resident #3, Morphine Sulfate liquid 20 milligrams/milliliter, has an expiration date of 8/13 on the bottle. Lot #2592028. Resident #3 has received three doses of pain medication from this bottle of Morphine. Confirmation was made on 8/18/14 at 12:53 PM, by both the Licensed Practical Nurse and the Health Director.	R176	**R176** Resident # 3's medication was properly disposed of on August 18, 2014 and has been replaced with a medication with a valid expiration date. Nursing staff will check expiration dates whenever administering a medication for a clearly marked expiration date. Expired medication will not be administered and will be properly disposed of according to facility policy. The Health Services Director or designee will conduct random audits of medications on a regular basis to assure compliance and report the results of these audits to the Quality Assurance Committee on a quarterly basis. 10/24/14	
R179 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff	R179		

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R179	Continued From page 5 demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on interview and employee file review for 1 or 5 employees, the facility failed to ensure that staff who provide direct care to residents, have at least twelve (12) hours of training each year. The findings include the following: Per review of employee educational file for one employee, s/he did not have the 12 hours of required education in the areas of Fire Safety, Emergency Response 1st Aide, Infection Control and General Care and Supervision of Residents. Per interview, on 8/19/14 at 4 PM, with Registered Nurse Vice President of Resident	R179	**R179** The employee in question has completed training in the 7 required areas. An online training system called *Relias Learning* has been put into practice to assure that all employees providing direct care to residents meet their mandated requirement for training. The Executive Director or his designee will monitor compliance on a regular basis and take corrective action if individual employees are out of compliance. Compliance reports will be made to the Quality Assurance Committee on a quarterly basis. 10/24/14	

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R179	Continued From page 6 Services, confirmation was made that the employee did not meet the annual twelve hour requirement.	R179	**R181** Employment of the individual in question has been reported to the Division of Licensing & Protection and a variance has been requested. Anyone being considered for employment in the future with a criminal record will be reported to the Division and a request for a variance will be requested and granted before an offer of employment is made. The Executive Director will monitor all criminal background checks and make the appropriate reports and requests to the Division of Licensing & Protection. The Vice President of Clinical Services will conduct random audits to assure compliance.	10/24/14
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on interview and record review for 1 of 5 sampled employees, the facility has on staff a person who has been convicted of a felony. The findings include the following: Per record review on 8/18/14 at approximately 4 PM, an employee file evidences a criminal background of a felony. The background request	R181		

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R181	Continued From page 7 was made in October of 2011. Per interview with the Executive Director on 8/18/14 at 4:17 PM, confirmation is made that a variance from the Licensing Agency to employ the individual was never requested.	R181		
R188 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review for 1 of 6 sampled residents, the facility failed to ensure that the medical record includes a recent photograph of the resident, unless the resident objects. The findings include the following: Per medical record review on 8/19/14 at approximately 11 AM, Resident #3 has no evidence of a photograph or information	R188	**R188** Resident # 3 now has a current photograph in the medical record and Medication Administration Record. All current residents have a photograph in their medical record and MAR. Any new resident moving in will have a current photograph taken on the day of admission and placed in their medical record and MAR. The Health Services Director will conduct random audits on a regular basis to assure compliance and report the results of these audits to the Quality Assurance Committee on a quarterly basis. 9/24/14	

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R188	Continued From page 8 identifying the resident's refusal to obtain an identifying photograph. Per interview with Licensed Practical Nurse at 11:43 AM, confirmation is made that s/he can not locate a photograph for this resident.	R188	**R206** The incidents involving resident # 6 have been reported to Adult Protective Services and the Division of Licensing & Protection. All future incidents of suspected resident to resident abuse will be reported APS and the Division of Licensing & Protection within 48 hours according to regulation. Staff have been in-serviced to report suspected abuse to the Health Services Director, supervising nurse and/or Executive Director immediately to assure compliance with the 48 hour rule. The Health Services Director or designee will monitor daily shift to shift reports to assure that all suspected abuse has been reported and conduct periodic in-services on report resident abuse.	
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18. Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record reviews, the facility failed to assure that reports of multiple incidents of suspected physical and verbal abuse were reported to Adult Protective Services as required. The findings include the following. Per medical record review on 8/20/14 at approximately 12 noon, for Resident #6, nursing progress notes document the following: a) 3/11/13-Resident very confrontational and rude this evening to all residents and staff. b) 3/30/13-Resident involved in altercation with a female resident. c) 5/16/13-Resident was found in her/his room hitting another resident who was on the ground in	R206		10/24/14

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R206	Continued From page 9 her/his room. It is unclear if Resident #6 caused the resident on the floor to fall or not. d) 6/14/13-Resident with an episode of increased agitation and slapped a male resident seated at the dining room table. e) 10/1/13-Resident sitting at the table at lunch, became agitated after taking her/his medications, stood up and hit the Resident Attendant (RA) then proceeded to slap a female resident on the upper arm. f) 11/14/13-Resident attacked fellow residents, when staff intervened Resident #6 then attacked the RA. Resident #6 held one of the resident's wrist and tried to hit and punch the RA. Per interview with the Health Director on 8/20/14 at 2:30 PM, confirmation was made that all of the above incidents occurred as documented. Per interview with Licensed Practical Nurse (LPN) on 8/20/13 at 2:30 PM, confirmation is made that protocol is to notify the Nursing Supervisor/Health Director of such incidents. LPN also confirms that there is no documentation identifying that the Health Director was notified of any of the above incidents. Per review of facility policy required reports are to be made within forty-eight (48) hours of allegations of suspicion of abuse, neglect or exploitation of a vulnerable adult. Cross-cited to R208 and R224.	R206		
R208 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation	R208		

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R208	Continued From page 10 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record reviews, the facility failed to assure that reports of a pattern of multiple incidents of abusive behavior, were reported to the licensing agency as required. The findings include the following. Per medical record review on 8/20/14 at approximately 12 noon, for Resident #6, nursing progress notes document the following: a) 3/30/13-Resident #6 was involved in altercation with Resident #5. b) 5/16/13-Resident #6 was found in her/his room hitting another resident who was on the floor in the room. Staff are unable to recall who the victim was and there is no documentation in the progress notes that identify the victim. It is unclear if Resident #6 caused the resident on the floor to fall or not. c) 6/14/13-Resident #6 noted to have increased agitation while seated at the dining room table and slapped Resident #9 across the face. d) 10/1/13-Resident sitting at the table at lunch, became agitated after taking her/his medications, stood up and hit the Resident Attendant (RA) then proceeded to slap Resident #10 on the upper arm.	R208	**R208** All suspected incidents of resident to resident abuse are now reported immediately to the supervising nurse, Health Services Director and/or Executive Director immediately after assuring the safety of the alleged victim. Such incidents are documented in the medical record of the alleged abuser and victim and reported to the physician and the person identified in the medical record as first contact. All staff have been in- serviced on reporting and documentation protocols. The Health Services Director or designee will review the documentation within 24 hours of the incident to assure compliance with this standard and that the incident will be reported to APS and the Division of Licensing & Protection within 48 hours as required by regulation. 10/24/14	

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R208	Continued From page 11 e) 11/14/13-Per nurses progress notes, documentation evidences that Resident #6 attacked Resident #4 by pushing her/him against the hallway wall. Staff intervened and then Resident #6 attacked the RA. Resident #6 then proceeded to hold the wrist of Resident #4 and attempted to hit and punch the RA. Per interview with the Health Director on 8/20/14 at 2:30 PM, confirmation was made that all of the above incidents occurred as documented. Per interview with Licensed Practical Nurse (LPN) on 8/20/13 at 2:30 PM, confirmation is made that protocol is to notify the Nursing Supervisor/Health Director of such incidents. LPN also confirms that there is no documentation identifying if the Health Director was notified of any of the above incidents. Per review of facility policy required reports are to be made within forty-eight (48) hours of allegations of suspicion of abuse, neglect or exploitation of a vulnerable adult.	R208		
R224 SS=E	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record reviews, the facility failed to protect residents from six (6) incidents of mental, verbal and/or	R224		

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R224	Continued From page 12 physical abuse between the dates of 3/11/13 through 11/14/13 (failed to protect Residents #4, #5, #9, #10 and an unknown resident). The findings include the following: Per medical record review on 8/20/14 at approximately 12 noon, for Resident #6, nursing progress notes document the following: a) 3/30/13-Resident #6 was involved in altercation with Resident #5. b) 5/16/13-Resident #6 was found in her/his room hitting another resident who was on the floor in the room. Staff are unable to recall who the victim was and there is no documentation in the progress notes that identify the victim. It is unclear if Resident #6 caused the resident on the floor to fall or not. c) 6/14/13-Resident #6 noted to have increased agitation while seated at the dining room table and slapped Resident #9 across the face. d) 10/1/13-Resident sitting at the table at lunch, became agitated after taking her/his medications, stood up and hit the Resident Attendant (RA) then proceeded to slap Resident #10 on the upper arm. e) 11/14/13-Per nurses progress notes, documentation evidences that Resident #6 attacked Resident #4 by pushing her/him against the hallway wall. Staff intervened and then Resident #6 attacked the RA. Resident #6 then proceeded to hold the wrist of Resident #4 and attempted to hit and punch the RA. Per interview with the Health Director on 8/20/14 at 2:30 PM, confirmation was made that all of the above incidents occurred as documented. Per interview with Licensed Practical Nurse (LPN) on 8/20/13 at 2:30 PM, confirmation is made that	R224	**R224** Resident # 6 now has private caregivers and is always supervised whenever she may have contact with other residents. In addition resident can no longer ambulate. There have been no further incidents since November of 2013. All incidents of suspected resident to resident abuse are reported to the supervising nurse. Health Services Director or Executive Director as soon as the safety of the alleged victim has been assure proper documentation and notification protocols will then be followed. The incident will be reported the APS and the Division of Licensing & Protection within 48 hours per regulations. If necessary, additional interventions including but not limited to behavior care plans will be implemented to prevent further incidents. The Health Services Director will continue to monitor all residents at risk, implement further interventions as necessary and report to the Quality Assurance Committee on a quarterly basis.	10/24/14

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R224	Continued From page 13 protocol is to notify the Nursing Supervisor/Health Director of such incidents. LPN also confirms that there is no documentation identifying if the Health Director was notified of any of the above incidents.	R224		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that all perishable food is labeled and dated. The findings include the following: 1. Per observation on 8/18/14 at approximately 10:40 AM, during a tour of the Dietary Department with the Dietary Service Worker, the dry storage area was found to have dried cereal, dried apricots, uncooked brown rice, uncooked pasta and graham cracker crumbs in their original multiple serving packages, open, unsealed and not dated. On the bottom storage shelf was a 50 pound bag of white flour, also opened, unsealed and not dated. A large refrigerator in the department contained a pitcher of brown liquid with no label or date. A large plastic cone containing whipped cream open, partially used with no date. Located to the right of the refrigerator is a walk in	R247	**R247** All opened and/or prepared foods are now properly sealed and dated. Reusable plastic lids have been purchased for the ice cream containers to assure the quality and integrity of the product. Any outdated food is disposed of as soon as it is out of compliance. The Food Services Director will conduct regular rounds to assure compliance with this standard. The Executive Director or his designee will conduct random audits to monitor compliance and will report the results of these audits to the Quality Assurance Committee. 10/24/14	

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R247	Continued From page 14 refrigerator and freezer, the following items were found with labels but no dates: 8 gallon container of salad dressing partially used, a partially used chocolate cake in a covered baking pan and multiple small salads prepared for use. Walk-in freezer was noted to have four (4), three (3) gallon containers of ice cream partially used with the lids crushed and exposing the product. Exposure to freezer temperatures may cause crystallization and alter the flavor of the dessert. Per interview with the Dietary Service Worker, confirmation is made during the tour that all of the above was observed. 2. Per observation on 8/20/14 at approximately 8:30 AM, with the Health Director on the Memory Care Unit, the dining room refrigerator was noted to have three multi-serving containers of pureed fruit/yogurt stored with no dates or labels. The refrigerator was noted to have dried, old, dark, yellow liquid caked at the base of the storage bins. Confirmation at the time of the tour by the Health Director, was made that the refrigerator needed cleaning and the food should be labeled and dated.	R247		
A 962 SS=D	XI Physical Plant 11.2 At a minimum, resident units shall include the following: 11.2.k Each unit shall be equipped with an emergency response system that will alert the on-duty staff. This Statute is not met as evidenced by: Based on observation, staff interview and medical	A 962		

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A 962	Continued From page 15 record review, the facility failed to provide an emergency response system for 1 of 6 sampled residents. For Resident #5, the findings include the following: Per medical record review, Resident #5 admitted on 4/6/11 with diagnoses to include Alzheimer's Disease, Coronary Artery Disease, Glaucoma and Behavioral Symptoms of severe distress. Per observation during a facility tour on 8/18/14 at 10:21 AM, the resident is observed to be in bed with bilateral 1/2 side rails in the up position, lying on an alternating pressure mattress and has a protective mat on the right side of her bed on the floor to prevent injury in case of a fall. Resident assessment and service plan dated 8/1/14 signed by the Registered Nurse (RN), identifies that resident requires total care by staff, is transferred by two (2) person physically assisted, is totally dependent on staff for all meals and nourishments offered, is unable to control bowel and bladder and requires staff assistance for toileting/incontinent care, is receiving Hospice Care and requires behavior monitoring/management. Resident service plan identifies that Resident #5 has difficulty speaking and staff to assist with communication due to overall decline and end of life. Per observation during tour at 10:21 AM, Resident #5 is noted to be unable to ambulate to call light (pull-cord), located in the bathroom, in the apartment off the bedroom. When the Concierge (who was conducting the tour), was asked how does the resident notify staff if s/he needs assistance? The response was that s/he has a monitor for sound in the room. The monitor could not be located at this time and after inquiring, confirmation was made at approximately 10:30 AM, by the Health Director,	A 962	**R962** A monitoring device was placed in resident # 5's unit on August 18, 2014 and is still in place. All units are equipped with an emergency pull cord in accordance with regulations. In addition, there is a nurse call pendant system for those residents that have been assessed with the ability to use one. Residents residing on the memory impaired area have been assessed for the ability to communicate their need for assistance. Any resident assessed unable to communicate the need for assistance will have a monitoring device placed in their unit and/or have a care plan for regular safety checks by the staff when in their unit and their service plans will be updated. The Health Services Director or designee will assess any new resident moving onto the memory impaired area for the ability to communicate the need for assistance and create an appropriate plan of care to meet their needs and screen existing residents for decline in their ability to communicate the need for assistance and care plan accordingly.	

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A 962	Continued From page 16 that a unit was on order and that the resident is unable to get to utilize the pull-cord to alert staff if she is in need.	A 962	The Health Services Director or designee will report to the Quality Assurance Committee on a quarterly basis the status of these residents. 10/24/14	